

DEPARTMENT OF BENEFIT PAYMENTS

744 P Street, Sacramento, CA 95814



January 8, 1975

ALL-COUNTY LETTER NO. 75-8

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: Guide Dog Special Allowance - Reporting of Blind Excess Value Home
Case Data

REFERENCE: All County Letter Number 74-239

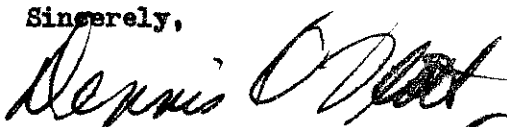
Attached are copies of Form SC-5 to be used by counties to transmit information on Blind EVH recipients to the Department of Benefit Payments. As indicated in All County Letter No. 74-239, this information is needed in the administration of the new Guide Dog Special Allowance, and can only be obtained from County Welfare Departments.

For the first reporting month of January, counties should complete one form for each current blind EVH recipient or for blind individuals who received EVH payments in at least one of the months of October, November or December 1974. This should be done by January 20, 1975. If your county does not currently have any blind EVH recipients, please notify the Adult Program Management Branch of this department by letter.

After the initial reporting phase, counties should use the SC-5 to notify the Department of Benefit Payments of any new or terminated blind EVH cases. This should be done by the 10th of each month.

Questions regarding this letter should be directed to the Adult Program Management Branch 744 P Street, Sacramento, CA 95814, telephone (916) 445-0813.

Sincerely,


DENNIS O. FLATT
Deputy Director

Attachment

cc: CWDA

OBsoleteSuperseded by ACL # 77-15Issued 3-17-77

BLIND EXCESS VALUE HOME RECIPIENT REPORT FORM

This form is to be used by counties to provide information on Blind Excess Value Home recipients to the Department of Benefit Payments to be used in administering the Guide Dog Special Allowance.

Complete Sections A and B for each blind EVH recipient who is currently eligible at the time this form is initially provided to the county and for new blind EVH eligibles who subsequently become EVH recipients.

Complete Sections A and C for each blind EVH recipient at the point such recipient is terminated from the EVH Program.

**COMPLETE THIS FORM FOR
BLIND EVH RECIPIENTS ONLY**

County _____

Contact Person _____

Telephone _____

A. RECIPIENT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)		RECIPIENT RESIDENCE ADDRESS		TELEPHONE
PAYEE NAME (IF DIFFERENT THAN RECIPIENT) (LAST, FIRST, MI)		PAYEE ADDRESS (IF DIFFERENT THAN RESIDENCE ADDRESS)		TELEPHONE
RECIPIENT SOCIAL SECURITY NUMBER	BIRTH DATE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single	

B. RECIPIENT ELIGIBILITY STATUS

<input type="checkbox"/> New Case <input type="checkbox"/> Restoration	EFFECTIVE DATE OF AID ____/____/____	INDICATE WHETHER RECIPIENT RECEIVED EVH PAYMENTS FOR THE FOLLOWING MONTHS OF 1974 <input type="checkbox"/> October <input type="checkbox"/> November <input type="checkbox"/> December
IF MARRIED, IS SPOUSE A RECIPIENT OF: EVH <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME OF SPOUSE (LAST, FIRST, MIDDLE)	

C. TERMINATIONS

EFFECTIVE DATE OF TERMINATION ____/____/____	REASON FOR TERMINATION	IS RECIPIENT TRANSFERRING TO SSI/SSP <input type="checkbox"/> Yes <input type="checkbox"/> No
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**MAIL COMPLETED FORMS TO: GUIDE DOG SPECIAL ALLOWANCE
DEPARTMENT OF BENEFIT PAYMENTS
744 P STREET
SACRAMENTO, CALIFORNIA 95814**